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Fall-Related Injuries During the Holiday Season — United States, 2000–2003

Although fall-related injuries occur throughout the year (*1*), few studies have analyzed seasonal patterns (*2–4*), and none have examined the extent of such injuries associated with holiday decorating. To characterize nonfatal fall injuries associated with decorating or related activities, CDC analyzed data from the National Electronic Injury Surveillance System All Injury Program (NEISS-AIP) for three winter holiday seasons. This report summarizes the results of that analysis, which indicated that, during 2000–2003, an estimated 17,465 persons were treated in U.S. hospital emergency departments (EDs) for holiday-decorating–related falls. Approximately 62% of those injured were aged 20–49 years; approximately 43% of injuries were caused by falls from ladders; and males were 40% more likely than females to be injured. Prevention strategies should focus on raising awareness about falls and promoting safety practices during the holiday season.

For this analysis, the holiday season was defined as November 1–January 31, when decorating or related activities (e.g., stringing and removing outdoor lights) usually occur. A fall-related injury was defined as one received when a person descended because of the force of gravity and struck a surface at the same or lower level. A case was defined as an unintentional fall-related injury that occurred to a person during the holiday season and included a product description (e.g., holiday lights) or a brief narrative in the NEISS-AIP database that listed decorating or a related activity as contributing to the injury.

To characterize these injuries, NEISS-AIP data were analyzed for three holiday seasons combined (i.e., November 1, 2000–January 31, 2001; November 1, 2001–January 31, 2002; and November 1, 2002–January 31, 2003). NEISS-AIP, operated by the Consumer Product Safety Commission, collects data about initial visits for all types and causes of injuries treated in U.S. EDs. These data are drawn from a nationally representative subsample of 66 of 100 NEISS-AIP hospitals selected as a stratified probability sample of hospitals in the United States (*5*). Data are collected from medical records, and the most severe injury is recorded for each case. Data for each case include a two-line narrative about information regarding the circumstances of the injury.

Data were weighted by the inverse probability of selection and summed to produce national estimates. Confidence intervals (CIs) were calculated by using a direct variance estimation procedure that accounted for the sample weights and complex sample design. Denominators for rates were calculated by summing the proportional fraction of the population for each year, based on U.S. Census population estimates (*6*).

During 2000–2003, a total of 225 fall-related injuries that occurred to persons treated in participating EDs were attributed to holiday decorating or related activities, yielding a weighted national estimate of 17,465 (95% CI = 12,751–22,179) injuries, an average of 5,822 injuries per season. The overall injury rate was 8.1 per 100,000 population (CI = 5.9–10.3). The majority of injuries (62%) occurred to persons aged 20–49 years. Persons aged >49 years sustained 24%, and persons aged 0–19 years sustained 15% of fall-related injuries.

Males sustained more injuries than females (58% versus 42%, respectively), although the rates for males (9.6) and females (6.7) did not differ significantly (relative rate [RR] = 1.4; CI = 0.8–2.1) (Table). The majority of falls were from

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TABLE. Estimated number, percentage, and rate* of persons treated in hospital emergency departments for fall-related injuries, by sex, structure involved, part of the body injured, injury diagnosis, and disposition — United States, November 1–January 31, 2000–2003

Category	Weighted no. (N = 17,465)	(%)	Rate	(95% CI†)
Sex				
Male	10,147	(58.1)	9.6	(6.9–12.4)
Female	7,318	(41.9)	6.7	(4.4–9.0)
Total	**17,465**	**(100.0)**	**8.1**	**(5.9–10.3)**
Structure involved				
Ladder	7,439	(42.6)	3.5	(2.3–4.6)
Roof	2,290	(13.1)	1.1	(0.5–1.7)
Furniture	1,906	(10.9)	0.9	(0.5–1.3)
Stairs	504	(2.9)	§	§
Porch	253	(1.4)	§	§
Other	2,424	(13.9)	1.1	(0.6–1.7)
Not specified	2,649	(15.2)	1.2	(0.7–1.8)
Part of body injured				
Arm/Hand	4,115	(23.6)	1.9	(1.2–2.7)
Leg/Foot	3,878	(22.2)	1.8	(1.2–2.4)
Upper trunk	3,919	(22.4)	1.8	(1.1–2.6)
Lower trunk	3,400	(19.5)	1.6	(0.9–2.3)
Head/Neck	2,153	(12.3)	1.0	(0.6–1.4)
Injury diagnosis				
Fracture	5,905	(33.8)	2.8	(1.7–3.8)
Contusions/Abrasions	4,197	(24.0)	2.0	(1.2–2.7)
Strain/Sprain	3,961	(22.7)	1.9	(1.2–2.5)
Laceration	1,836	(10.5)	0.9	(0.5–1.2)
Other	1,566	(9.0)	0.7	(0.4–1.1)
Disposition				
Treated and released	15,358	(87.9)	7.2	(5.1–9.2)
Hospitalized/Transferred	2,107	(12.1)	1.0	(0.6–1.4)

* Per 100,000 population.
† Confidence interval.
§ Estimates are unstable because they are based on <20 cases or the coefficient of variation is >30%.

ladders (e.g., while hanging holiday lights), followed by roofs (e.g., while mounting an artificial Christmas tree on the roof), furniture (e.g., while standing on a table decorating a Christmas tree, standing on a chair hanging holiday decorations, or standing on a step stool when hanging a tree topper), stairs, and porches. Other falls were caused by tripping over or slipping on holiday-related objects (e.g., tree skirts or ornaments). Among 46% of injured persons, injuries occurred to the extremities (i.e., arm/hand and leg/foot); most persons (88%) examined in EDs were treated and released, and 12% were hospitalized. Fractures were the most commonly reported injury (34%); approximately half (51%) of the fractures were caused by falls from ladders. Of those who fell from ladders, nearly half (47%) were hospitalized.

Circumstances and outcomes differed by sex. Males were significantly more likely than females to sustain injuries falling from ladders (RR = 2.4; CI = 1.0–3.7; p = 0.05) or from

ladders and roofs combined (RR = 3.1; CI = 1.8–4.5; p = 0.002.) For both males and females, rates for types of injuries were highest for fractures (3.5 and 2.0, respectively). Although males were at higher risk than females for sustaining fractures, the difference was not statistically significant.

Reported by: *JA Stevens, PhD, Div of Unintentional Injury Prevention; M Vajani, MPH, Office of Statistics and Programming, National Center for Injury Prevention and Control, CDC.*

Editorial Note: This is the first study to provide national estimates of fall-related injuries associated with holiday decorating or related activities. The findings in this report indicate that approximately 5,800 persons each year were treated in hospital EDs during the holiday period for these injuries. Males were 40% more likely than females to be injured in falls. The majority of cases (62%) occurred among young and middle-aged adults. In contrast, adults aged 20–49 years account for only 30% of persons treated for all fall-related injuries annually (*1*). In addition, 12% of patients were hospitalized for holiday-related falls, compared with 9% hospitalized annually for fall-related injuries.

Although decorating-related injuries represent less than 1% of the 1.9 million injuries from falls that occur each holiday season, most of these injuries are preventable. Approximately half the injuries (56%) were caused by falls from considerable heights (e.g., ladders and roofs), and an additional 11% were caused by falls from moderate heights (e.g., tables, chairs, beds, and step stools). Using ladders was a common risk factor for fall injuries. A recent telephone survey indicated that ladders are used by persons in 60% of households nationwide (*7*). The findings in this report indicated that falls from ladders accounted for nearly half of all fractures treated. Males were twice as likely as females to be injured by falls from ladders, possibly because men used ladders more frequently.

The findings in this report are subject to at least three limitations. First, the number of injuries likely was underestimated because it included only those persons who were treated in hospital EDs; the study did not include persons who were treated in physician offices or other outpatient settings or persons who did not receive medical attention. Second, 15% of the narratives did not describe the product involved, and the product was classified as "not specified." Finally, although the majority of patients were treated and released, NEISS-AIP does not include information about long-term outcomes such as mobility limitation, functional impairment, need for outpatient surgery, or rehabilitation.

The holiday season can be enjoyed safely by taking certain precautions to avoid falls when decorating. Heightened public awareness is a key element for reducing holiday-related injuries. Prevention strategies should focus on recognizing the possibility of falls, using ladders safely (Box), using safer alternatives such as step stools instead of furniture when hanging decorations, and increasing awareness of seasonal fall hazards. Safety practiced during the holiday season also might improve safety throughout the year.

BOX. Prevention strategies for ladder safety

- Ensure the ladder is on secure and level ground before climbing.
- Space the base of the ladder 1 foot away from the wall for every 4 feet it extends up.
- Stay centered between the rails of the ladder. Do not overreach — move the ladder.
- Do not stand on the top two rungs of the ladder.
- To reach a roof, extend the ladder at least 3 feet beyond the edge of the roof.
- Keep the area clear around the top and bottom of the ladder.
- Ensure step ladders are locked open securely. Never use a folding step ladder when it is closed.

Source: Adapted from guidelines from the Occupational Safety and Health Administration and the Consumer Product Safety Commission. Additional information about ladder safety is available at http://www.osha.gov/SLTC/etools/construction/falls/4ladders.html and at http://www.cpsc.gov/cpscpub/pubs/ladder.html.

References

1. CDC. Web-based Injury Statistics Query and Reporting System (WISQARS™). US Department of Health and Human Services, CDC, National Center for Injury Prevention and Control; 2004. Available at http://www.cdc.gov/ncipc/wisqars.
2. Jacobsen SJ, Sargent DJ, Atkinson EJ, O'Fallon WM, Melton LJ III. Contribution of weather to the seasonality of distal forearm fractures: a population-based study in Rochester, Minnesota. Osteoporos Int 1999;9:254–9.
3. Crawford JR, Parker MJ. Seasonal variation of proximal femoral fractures in the United Kingdom. Injury 2003;34:223–5.
4. Wareham K, Johansen A, Stone MD, Saunders J, Jones S, Lyons RA. Seasonal variation in the incidence of wrist and forearm fractures, and its consequences. Injury 2003;34:219–22.
5. Schroeder T, Ault K. National Electronic Injury Surveillance System All Injury Program: sample design and implementation. Bethesda, MD: US Consumer Product Safety Commission; November 2001.
6. US Bureau of the Census. Population projections program, population division, 2002. Available at http://www.census.gov/population/www/projections/popproj.html.
7. Marshall SW, Runyan CW, Yang J, et al. Prevalence of selected risk and protective factors for falls in the home. Am J Prev Medicine (In press).

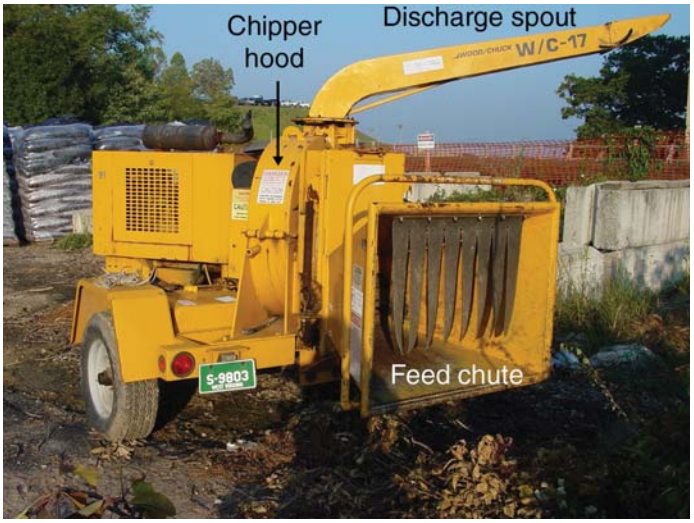
Fatal and Nonfatal Occupational Injuries Involving Wood Chippers — United States, 1992–2002

Tree damage from storms and routine tree-trimming operations prompt the need for disposing of branches and brush. Mobile wood chippers (Figure) shred branches and tree trimmings into mulch. Branches are fed into a chute, in which rotating blades macerate the wood. Mobile chippers pose potential dangers to operators, who can become caught in the feed mechanism and pulled into the rotating chipper knives or struck by the hood of the machine while it is being opened or closed with the knives still rotating. This report summarizes data describing fatal and nonfatal injuries related to occupational wood chipper use, which indicate that those working with mobile wood chippers are at risk for serious injury and death, but that these injuries can be prevented through proper training, machine maintenance, and the use of personal protective equipment.

To describe fatal injuries associated with wood chippers, CDC analyzed 11 years of data from the Bureau of Labor Statistics (BLS) Census of Fatal Occupational Injuries (CFOI) for 1992–2002 (the most current data available to CDC)*. Cases were selected if the primary or secondary source of injury was a chipper (source code 3231). After a review of all narrative descriptions, nonmobile chippers (e.g., those used as stationary equipment in saw mills) were removed from the analysis of fatal injuries. Costs were calculated by using the cost-of-illness approach (*1*). To assess nonfatal injuries, CDC reviewed 10 years of data reported by the BLS Survey of Occupational Injuries and Illnesses for 1992–2001 by using the same source code†. This data set captures nonfatal cases involving days away from work. For nonfatal injuries, narrative case descriptions were not available for review; therefore, removing cases involving nonmobile chippers was not possible.

* Using death certificates, worker's compensation reports, state and federal agency records, and other supporting documents, CFOI collects data on all fatal occupational injuries in the 50 states and the District of Columbia to determine worker demographics and the circumstances and causes of fatalities. CFOI data files provided to CDC by BLS do not include New York City.

FIGURE. Mobile wood chipper



Fatal Cases Involving Mobile Wood Chippers

During 1992–2002, a total of 31 occupational injury deaths were attributable to mobile chippers. All decedents were male; mean age at death was 35 years (range: <20–60 years). Of these deaths, 12 (39%) occurred among persons aged 25–34 years. Seventeen (55%) occurred in the agriculture, forestry, and fishing industry, and seven (23%) occurred in the manufacturing industry. Twenty-one (68%) were the result of being caught or compressed by the chipper, and nine (29%) were the result of being struck by the machine or a machine part. Thirteen (42%) of the fatally injured workers were groundskeepers, and five (16%) were machine operators, assemblers, and inspectors. The remaining were classified as managers, forest conservation specialists, farm workers, carpenters, cutters/welders, miscellaneous machine operators, and construction and nonconstruction laborers. Approximately one third of the events occurred in July or August. Of 26 cases among persons for whom ethnicity was known, seven (27%) were among Hispanics. Societal costs of all chipper-related fatalities (primary source code 3231) for 1992–2001 are estimated at $28.5 million in 2003 dollars (CDC, unpublished data, 2004§).

Nonfatal Cases Involving Mobile and Stationary Wood Chippers

During 1992–2001, an estimated 2,042 injuries resulted from working with chippers, an average of 204 per year. Of these injuries, 47% occurred among workers aged 25–34 years. In 1,224 (60%) of the workers, the injuries were to an upper extremity. During 1992–1996, an estimated 155 amputations

† The Survey of Occupational Injuries and Illnesses is a federal/state program in which reports from employers from their OSHA-reportable injuries are collected annually from nearly 176,000 private-industry establishments and processed by state agencies cooperating with BLS, and national estimates are made. Government employees, private household workers, the self-employed, and farms with fewer that 11 employees are excluded. Information about nonfatal cases involving days away from work during 1992–2001 is available at http://www.bls.gov/iif/home.htm.

§ Data are available by request at e-mail, egb6@cdc.gov.

caused by injuries from chippers occurred. In approximately one quarter of the cases, the injured person missed >30 days from work. Sixteen percent of persons injured had worked <3 months at the job at the time of injury; another 18% had worked 3–11 months.

Reported by: *TW Struttmann, Div of Safety Research, National Institute for Occupational Safety and Health, CDC.*

Editorial Note: The primary risks associated with use of wood chippers include being caught in the rotating knives of the machine and being struck by flying objects (e.g., the chipper hood, which can fly off if it contacts the rotating blades). Use of mobile wood chippers might increase after storm damage, thus exposing more persons to these hazards. In addition, chippers are available from equipment rental companies and can be rented and used by homeowners and others.

Employers, workers, and others who use wood chippers can reduce their risk for injury. Personal protective equipment recommended during chipper operations includes hard hat, eye protection, hearing protection, safety boots, and close-fitting outer clothing (*2*). Worker training should include instruction in 1) the correct operation of safety devices and controls consistent with the recommendations of the manufacturer, 2) the need to keep hands and feet away from the feed chute, 3) proper procedures for feeding brush and limbs into the feed chute, and 4) standing to the side in reach of the emergency shut-off when feeding branches. A long branch should be used as a push stick to feed shorter material into the chipper. Small material such as twigs and leaves should be put directly into the transport container (e.g., dump truck) instead of into the chipper. The area around the chipper should be kept clear to reduce tripping hazards. Equipment rental companies should provide training or ensure that renters receive safe-operating instructions from the manufacturer.

To protect users from being struck by flying hoods, chippers should be thoroughly inspected each day before start-up. The hood should completely cover the chipper knives, and workers should ensure that knives come to a complete stop before opening the hood. Persons aged <18 years should be prohibited from operating chippers (*3*).

The number of chipper-related deaths among Hispanic workers during 1992–2002 was consistent with the increase in total occupational deaths among Hispanic workers during that period. Deaths among Hispanic workers accounted for 8.6% of all occupational fatalities in 1992 and 15.2% in 2002 (*4*). The growth in the Hispanic labor force is projected to be 17% during 2004–2010, whereas the total labor force is estimated to increase only 7% (*5*).

After Hurricane Charley, the report, *Injury Associated with Working Near or Operating Wood Chippers* (*6*), which summarizes hazards and prevention recommendations, was made available to all extension agents in Florida through the University of Florida Extension Service (C. Lehtola, Department of Agriculture and Biological Engineering, University of Florida, personal communication, 2004). The report is available at http://www.cdc.gov/niosh/hid8.html; a Spanish translation is available at http://www.cdc.gov/spanish/niosh/docs/99-145sp.html.

The findings in this report are subject to at least five limitations. First, because chippers are used in multiple industries and occupations, the number of workers exposed could not be determined; therefore, rates and relative risk could not be calculated. Second, CFOI cases could have been coded to sources other than 3231. Third, nonfatal injury estimates are based on a sample of employer-reported injuries and might underestimate the number of injuries caused by chippers. Farms employing fewer than 11 persons and self-employed, government, and household workers were excluded from the survey. Fourth, removing stationary chippers from the data on nonfatal cases was not possible. Finally, the data presented in this report do not include injuries and deaths that might have occurred in nonwork settings.

Tree and branch removal is a necessary post-storm task. Deaths and injuries involving mobile chippers can be prevented through worker training, machine maintenance, and the use of personal protective equipment.

References

1. Biddle E. Economic cost of fatal occupational injuries in the United States, 1980–1997. Contemporary Economic Policy 2004;22:37–81.
2. American National Standards Institute, Inc. American national standard: pruning, repairing, maintaining, and removing trees, and cutting brush-safety requirements. Champaign, IL: American National Standards Institute, Inc.; 2000.
3. National Institute for Occupational Safety and Health. Recommendations to the U.S. Department of Labor for changes to hazardous orders; May 3, 2002. Available at http://www.cdc.gov/niosh/docs/nioshrecsdolhaz/pdfs/dol-recomm.pdf.
4. US Department of Labor, Bureau of Labor Statistics. Census of fatal occupational injuries 1992–2002. Available at http://www.bls.gov/iif/home.htm.
5. US Department of Labor, Bureau of Labor Statistics. Civilian labor force 2002–2012. Labor force data files. Available at ftp://ftp.bls.gov/pub/special.requests/ep/labor.force/clfa0212.txt.
6. National Institute for Occupational Safety and Health. Injury associated with working near or operating wood chippers. Cincinnati, OH: US Department of Health and Human Services, Public Health Service, CDC; 2001. DHHS publication no. (NIOSH) 99-145. Available at http://www.cdc.gov/niosh/hid8.html and http://www.cdc.gov/spanish/niosh/docs/99-145sp.html.

Salmonella Serotype Typhimurium Outbreak Associated with Commercially Processed Egg Salad — Oregon, 2003

On September 24, 2003, Oregon epidemiologists noted an increase in *Salmonella enterica* serotype Typhimurium isolates tested during September at the Oregon State Public Health Laboratories. Of 16 isolates, six had matching pulsed-field gel electrophoresis (PFGE) patterns. The laboratory findings prompted an investigation by Oregon Health Services and CDC that identified 18 cases of infection with *S.* Typhimurium linked to kits for making egg salad that were distributed by a vendor to a supermarket chain. The Food and Drug Administration (FDA) conducted an environmental investigation but was unable to determine the mechanism of contamination. This was the first reported *S.* Typhimurium outbreak associated with a commercially processed, widely distributed, hard-boiled egg product. Epidemiologists and other public health staff should continue to investigate apparent clusters of salmonellosis and be aware that even commercially processed egg products can be a source of *Salmonella*.

An outbreak-associated case was defined as diarrheal illness in an Oregon or Washington resident during September–October 2003 with a stool culture yielding *S.* Typhimurium with a PFGE pattern matching the outbreak pattern*. Local health department staff members in Oregon routinely interview patients with salmonellosis regarding high-risk exposures, date of illness onset, and severity of illness. Interviews usually are completed before serotyping. During September 25–26, a total of 11 (of 12) patients identified by September 25 were reinterviewed by using a more extensive questionnaire covering shopping and eating venues and consumption of approximately 400 foods. A matched case-control study also was conducted.

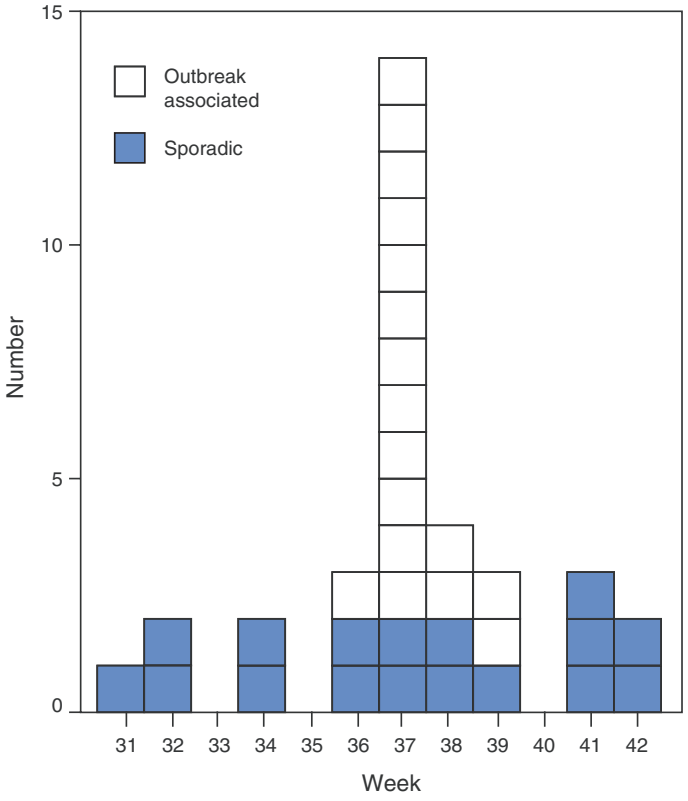
Results of the second questionnaire and a visit by investigators to a supermarket chain A outlet where patients had shopped were used to tailor a third and final questionnaire covering foods sold in the delicatessen section. This questionnaire was administered to eight of the 11 patients, along with eight controls matched to the patients by age group and telephone exchange. Patients were asked about their exposure to the delicatessen foods during the 5 days before their symptom onsets; controls were asked about their exposure to the delicatessen foods during the first 10 days of September. Odds ratios and Fisher exact p-values were calculated.

Egg salad found in the households of two patients was tested for *Salmonella* by enzyme-linked immunosorbent assay (ELISA). Cooked and packaged egg yolks and whites were submitted by the producer of the egg-salad kit, vendor A, to a private laboratory for culture. FDA aggregated separate samples of cooked egg yolks, egg whites, and dressing from unopened packages collected at two distribution centers of supermarket chain A and cultured for *Salmonella.*

Eighteen persons with outbreak-associated *S.* Typhimurium infections were identified (Figure): 17 residents of Oregon and one resident of Washington who sought care in an Oregon hospital. Dates of symptom onset ranged from September 6 to September 26. The median age of patients was 36 years (range: 4–58 years). They resided in nine different counties; 11 were male. Ten patients reported bloody diarrhea; two were hospitalized but recovered and were discharged after 1 day and 3 days, respectively.

No common exposures were evident from the initial interviews, and no specific food item was implicated by the results of the second questionnaire administered to the 11 patients identified by September 25. However, 10 of those 11

FIGURE. Number of patients with outbreak-associated and sporadic *Salmonella* serotype Typhimurium infections, by week of illness onset — Oregon*, 2003



* One outbreak-associated Washington patient is not shown.

* Designated as JPXX01.0981 by PulseNet, the national molecular subtyping network for foodborne surveillance, available at http://www.cdc.gov/pulsenet.

patients reported shopping at various outlets of supermarket chain A, and seven of the 10 reported consuming items from the delicatessen section.

Of the eight patients participating in the case-control study, the first patient to be interviewed noted that egg salad, which the patient had purchased from the delicatessen of a supermarket chain A outlet, was absent from the list of foods in the questionnaire. Egg salad, which had not been displayed for sale when investigators visited the delicatessen, was added to the questionnaire for all the interviews. Seven of the eight patients and three controls reported shopping at supermarket chain A (matched odds ratio [mOR] = ∞; 95% confidence interval [CI] = 0.9–∞; p=0.031). All eight patients and two controls reported eating delicatessen items from supermarket chain A (mOR = ∞; CI = 0.9–∞; p=0.063); seven of the eight patients and no controls reported eating egg salad from the delicatessen (mOR = ∞; CI = 1.44–∞; p=0.008). No other foods were associated with illness.

Supermarket chain A reported that its delicatessen egg salad was sold intermittently. Investigation by Oregon Health Services and FDA determined that kits for the egg salad were produced in a California plant operated by vendor A. At the plant, eggs were boiled and peeled, yolks and whites were chopped separately, and dressing was made from mayonnaise, pepper, and preservatives (i.e., sodium benzoate and potassium sorbate). The chopped egg whites, yolks, and dressing were sealed into separate plastic pouches and boxed together as kits. The egg salad was then prepared at individual stores by combining the contents of the pouches. Kits were stamped with a use-by date 40 days beyond the date of production at the plant. Ready-for-sale egg salad had a 3-day store shelf life. According to the dates that suspected kits were delivered from vendor A to the supermarket chain A distribution center, the eggs in the kits had been cooked 5–33 days before consumption. Supermarket chain A was the only customer for egg salad kits produced by vendor A.

Vendor A supplied its egg salad kits to supermarket chain A distribution centers in Arizona, California, Colorado, Oregon, and Washington. However, no case-patients in states other than Oregon and Washington were identified by review of PulseNet, communication with neighboring states, or via postings on *Epi-X*[†]. A spring 2004 query of PulseNet revealed that four *S.* Typhimurium isolates from Arizona that matched the outbreak pattern had been collected during September 14–24, 2003, but had not been assigned a pattern designation until November 21. In May, Arizona Department of Health Services could not locate three of these patients; the fourth did not recall eating egg salad.

Although the isolates from Arizona suggest more widespread distribution of contaminated product, at the time of the investigation, all patients appeared to have eaten egg salad provided to supermarket chain A by a single distribution center in Oregon. No unopened samples of lots distributed through this center were available for testing. Testing with ELISA detected no *Salmonella* antigen in either of the leftover egg salad samples obtained from patient households. *Salmonella* serotype Heidelberg was cultured from cooked egg yolk obtained at a distribution center in Washington. *Salmonella* serotype Braenderup was cultured from samples submitted by vendor A to a private laboratory. Vendor A voluntarily discontinued production of egg salad kits.

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Editorial Note: Each year in the United States, salmonellosis causes approximately 1.3 million cases of foodborne illness, 15,000 hospitalizations, and 500 deaths (*1*). *S.* Typhimurium, the most common serotype, represented 22% of human *Salmonella* isolates reported to CDC in 2002 (*2*). Contaminated eggs have been implicated as the vehicle in many *Salmonella* outbreaks (*3*). *Salmonella* serotype Enteritidis has been most commonly linked with shell eggs, but *S.* Typhimurium also has been the cause of numerous outbreaks (*4*) and might be just as likely as *S.* Enteritidis to colonize the reproductive tracts of chickens and eggs forming in the oviduct (*5*). Sporadic cases in Minnesota also have been linked to egg consumption (*6*). Although industry control measures have reduced overall egg contamination, *S.* Enteritidis still is found in approximately one in 20,000 eggs (*7*).

In this outbreak, *S.* Typhimurium was not found in cooked and packaged egg yolks and whites or in egg salad samples, and the specific mechanism of contamination remains undetermined. However, potential contributing causes could be inadequate cooking of the eggs, improper cooling of cooked eggs, or improper employee handling practices that allowed for recontamination of cooked eggs. Discovery of two other *Salmonella* serotypes in unopened packages in distribution centers suggests quality-control problems at the plant of vendor A.

Salmonella can survive inadequate cooking of eggs (*8*). Cooked eggs were implicated in a restaurant-associated *S.* Enteritidis outbreak in California (*9*). The Oregon outbreak in this report is the first in which a commercially

[†] The *Epidemic Information Exchange* is a web-based communications network (available at http://www.cdc.gov/epix) enabling the secure exchange of information among epidemiologists, laboratorians, and other public health professionals at CDC and state and local agencies.

processed, widely distributed hard-boiled egg product was identified as the vehicle for salmonellosis.

To avoid the possibility of foodborne illness, fresh eggs should be stored at ≤45°F (≤7°C). Eggs should be cooked until both the yolk and white are firm. Recipes containing eggs mixed with other foods should be cooked to an internal temperature of 160°F (71°C). In addition, pasteurized egg products should be substituted for raw eggs in dishes served without further cooking and care taken to prevent cross-contamination with raw eggs during preparation (*10*).

This investigation implicated egg salad kits from vendor A, contaminated before their distribution, as the common source of the outbreak. Public health surveillance led to rapid detection and investigation of the outbreak and to voluntary discontinuance of egg salad kit production by vendor A, likely preventing additional illness. Consumers and food producers should be reminded that eggs need to be stored properly and cooked thoroughly.

Acknowledgments

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References

1. Mead PS, Slutsker L, Dietz V, et al. Food-related illness and death in the United States. Emerg Infect Dis 1999;5:607–25.
2. CDC. *Salmonella* surveillance: annual summary, 2002. Atlanta, GA: US Department of Health and Human Services, CDC; 2003.
3. Tauxe RV, Pavia AT. Salmonellosis: nontyphoidal (Chapter 31). In: Evans AS, Brachman PS, eds. Bacterial infections of humans, epidemiology and control. 3rd ed. New York, NY: Plenum Medical Book Co.;1998:613–30.
4. St Louis ME, Morse DL, Potter ME, et al. The emergence of grade A eggs as a major source of *Salmonella* Enteritidis infections: new implications for the control of salmonellosis. JAMA 1988;259:2103–7.
5. Keller LH, Schifferli DM, Benson CE, Aslam S, Eckroade RJ. Invasion of chicken reproductive tissues and forming eggs is not unique to *Salmonella* Enteritidis. Avian Dis 1997;41:535–9.
6. Hedberg CW, David MJ, White KE, MacDonald KL, Osterholm MT. Role of egg consumption in sporadic *Salmonella* Enteritidis and *Salmonella* Typhimurium infections in Minnesota. J Infect Dis 1993;167:107–11.
7. US Department of Agriculture. *Salmonella* Enteritidis risk assessment: shell eggs and egg products. Washington, DC: US Department of Agriculture, Food Safety and Inspection Service; 1998. Available at http://www.fsis.usda.gov/ophs/risk.
8. Humphrey TJ, Greenwood M, Gilbert RJ, Rowe B, Chapman PA. The survival of salmonellas in shell eggs cooked under simulated domestic conditions. Epidemiol Infect 1989;103:35–45.
9. CDC. Outbreaks of *Salmonella* Enteritidis gastroenteritis—California, 1993. MMWR 1993;42:793–7.
10. Food and Drug Administration. Food safety facts for consumers: playing it safe with eggs. Rockville, MD: US Department of Health and Human Services, Food and Drug Administration, Center for Food Safety and Applied Nutrition; 2001. Available at http://www.cfsan.fda.gov/~dms/fs-eggs.html.

Brief Report

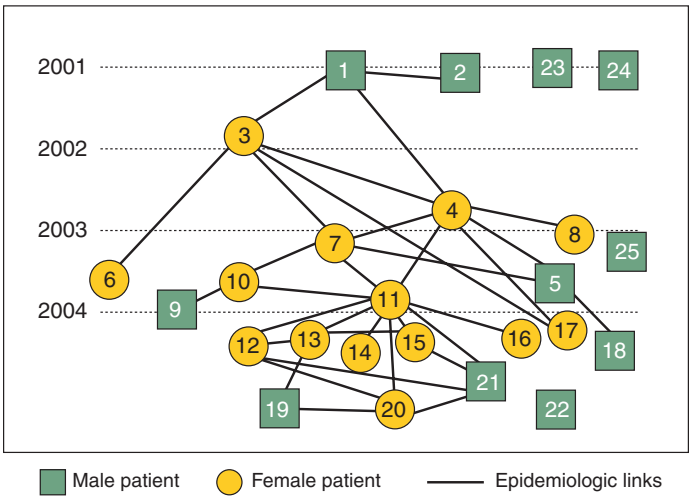
Tuberculosis Outbreak in a Low-Incidence State — Indiana, 2001–2004

States with fewer than 3.5 cases of tuberculosis (TB) per 100,000 population are designated as states with low incidence for TB, corresponding to CDC's interim target rate for 2000, with a goal to eliminate TB in the United States by 2010 (*1*). Indiana is a low-incidence state, with a TB case rate of 2.3 per 100,000 population in 2003. However, during 2000–2002, Allen County, Indiana, exceeded the state TB case rate with a mean case rate of 2.9 (range: 2.7–3.0) per 100,000 population. The TB case rate in Allen County increased to 4.7 per 100,000 population (with 16 patients reported with TB disease) in 2003 and to 7.0 per 100,000 population (with 12 patients reported with TB disease) during the first half of 2004. The Allen County Department of Health (ACDH), the Indiana State Department of Health, and CDC are investigating this ongoing TB outbreak. This report describes the preliminary results of the investigation, the efforts of ACDH to restructure its TB program, and the importance of maintaining TB-control efforts in low-incidence states.

During January 2001–June 2004, a total of 59 cases of TB disease were reported in Allen County. Cases in which patients had a matching *Mycobacterium tuberculosis* genotype or, when no isolate was available for genotyping, an epidemiologic link to a patient with TB disease, were considered outbreak related. Of the 59 cases investigated, 25 (42%) were outbreak related, 21 (84%) had epidemiologic links (Figure) and four (16%) had genotypic links only. The median age of outbreak-related TB patients was 27 years (range: 6 months–51 years). Nearly all patients (96%) were black, 14 (56%) were female, and 22 (88%) resided in four contiguous postal code areas. Of 16 patients who were tested for human immunodeficiency virus (HIV), all tested negative. Pulmonary TB was present in 18 (72%) patients. Six (24%) patients were highly infectious, with acid-fast bacilli (AFB) identified on sputum smear and cavitary lung lesions.

To examine whether other cases were outbreak related and to confirm the index patient, all available *M. tuberculosis* isolates from TB patients reported in Allen County from 1999 (the year the index patient first reported symptoms) through June 2004 were sent for genotyping by spoligotyping, mycobacterial interspersed repetitive unit (MIRU) typing, and IS6110-based restriction fragment-length polymorphism (RFLP) testing. Of these 38 isolates, 18 (47%) had matching spoligotypes and MIRU patterns, indicating that the 18 cases were likely outbreak related. RFLP testing on nine isolates

FIGURE. Year of diagnosis and epidemiologic links among tuberculosis patients* — Allen County, Indiana, 2001–2004



* Information pending on epidemiologic links for patients 22–25.

confirmed a matching nine-band pattern in eight isolates, with a one-band shift in the remaining isolate. RFLP testing of the remaining available isolates is pending.

A total of 516 contacts of the 25 linked patients have been identified. Of these, 423 (82%) were tested with at least an initial tuberculin skin test (TST); the remaining 18% are either pending follow-up or cannot be found. Among the tested contacts, 85 (20%) had positive TST results (induration ≥5 mm) (*2*), and 13 other persons reported a previous positive TST result. Of these 98 contacts, 13 (13%) received a diagnosis of TB disease upon further evaluation. The remaining 85 (87%) were candidates for latent TB infection (LTBI) treatment; 49 (58%) of the candidates started therapy, but, of these, 12 (24%) defaulted. For two (17%) of the persons who defaulted (patients 3 and 7) and one LTBI candidate who refused treatment (patient 4), infection progressed to TB disease. Because of matching isolate genotypes and epidemiologic links to other patients, these three patients are suspected as the sources of TB infection for 16 of 24 patients (patients 6–21) with TB disease (Figure). Had the three patients completed LTBI treatment, 16 TB cases might have been prevented. Each contact who defaulted cited lack of TB knowledge as a major barrier to completing LTBI treatment.

ACHD and CDC continue to identify new cases and contacts related to this outbreak. Investigation is under way for approximately 600 additional contacts associated with one of the AFB sputum smear-positive, pulmonary TB case-patients with cavitary lesions.

Achieving TB control in this outbreak will require 1) continuing contact investigation, 2) successful treatment of patients with newly diagnosed TB disease or LTBI, 3) TB education for health-care workers (HCWs) and the community, and 4) close patient management that includes directly observed therapy for LTBI in patients at high risk for TB disease (*2*). Recognizing this increased need for TB services and education, ACDH is restructuring its TB program and increasing financial and personnel resources. In addition, CDC is working with ACDH to develop educational material and programs for the TB clinic staff, local HCWs, and the community. Improved TB education and communication between HCWs and the community might expedite TB disease detection and increase adherence of patients to LTBI treatment. This TB outbreak demonstrates the limitations of gains in TB control and the importance of continued resource commitment to and preparedness for TB resurgences, even in low-incidence states (*3*).

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Acknowledgment

This report is based, in part, on contributors by T Douglas, MD, Epidemiology Program Office, CDC.

References

1. CDC. A strategic plan for the elimination of tuberculosis in the United States. MMWR 1989;38(No. S-3).
2. CDC. Targeted tuberculin testing and treatment of latent tuberculosis infection. MMWR 2000;49(No. RR-6).
3. CDC. Progressing toward tuberculosis elimination in low-incidence areas of the United States: recommendations of the Advisory Council for the Elimination of Tuberculosis. MMWR 2002;51(No. RR-5).

Notice to Readers

Eighth Annual Conference on Vaccine Research

The Eighth Annual Conference on Vaccine Research will be held May 9–11, 2005, in Baltimore, Maryland. The largest scientific conference devoted exclusively to vaccinology, it features both submitted abstracts and invited presentations across many disciplines to encourage the exchange of ideas and approaches for immunization against diverse human and veterinary pathogens and conditions. The conference is co-sponsored by CDC, the National Foundation for Infectious

Diseases (NFID), and 10 other national and international agencies, institutes, and organizations.

A new travel grants program, sponsored by the Bill and Melinda Gates Foundation, offers financial support to researchers in resource-limited countries to present their work at the conference. Deadline for submission of application and associated abstracts for travel grants is January 3, 2005.

Conference attendees can register online now. Deadline for online submission of abstracts for oral and poster presentations is February 7, 2005. Program announcements and information on abstract submission, registration, hotel reservation, and travel grant application are available at http://www.nfid.org/conferences/vaccine05; from NFID, Suite 750, 4733 Bethesda Avenue, Bethesda, MD 20814-5278; telephone 301-656-0003, ext. 19; fax 301-907-0878; or e-mail vaccine@nfid.org.

Notice to Readers

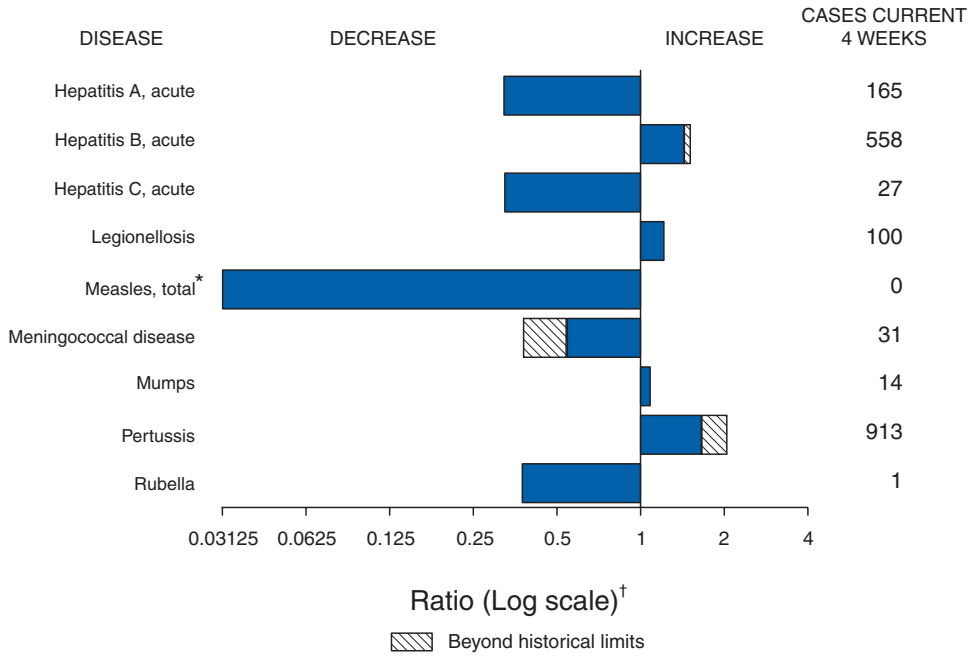
Publication of *Health, United States, 2004 with Chartbook on Trends in the Health of Americans*

CDC has published *Health, United States, 2004 with Chartbook on Trends in the Health of Americans*, the 28th edition of the annual report on the nation's health. The report includes 153 trend tables organized around four subject areas: health status and determinants, health-care use, health-care resources, and health-care expenditures. Information regarding racial, ethnic, and socioeconomic disparities in health is presented in several tables.

The 2004 chartbook included in the report assesses the state of the nation's health and how it has changed over time, both positively and negatively, by presenting trends and current information on selected determinants and measures of health status. Determinants of health include demographic factors, health-insurance coverage, health behaviors, and preventive health care; measures of health status focus on trends in mortality and limitations of activity caused by chronic health conditions. Although the health of persons overall in the United States has improved, the health of certain populations has lagged behind. This year's chartbook also includes a special section on prescription drugs, which have become an increasingly important component of health care.

The report is available from the National Center for Health Statistics at http://www.cdc.gov/nchs/hus.htm. Additional information is available by telephone at 301-458-4636 or by e-mail at nchsquery@cdc.gov.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals December 4, 2004, with historical data



* No measles cases were reported for the current 4-week period yielding a ratio for week 48 of zero (0).
† Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending December 4, 2004 (48th Week)*

	Cum. 2004	Cum. 2003		Cum. 2004	Cum. 2003
Anthrax	-	-	HIV infection, pediatric†¶	140	191
Botulism:	-	-	Influenza-associated pediatric mortality**	-	NA
foodborne	18	12	Measles, total	28††	52§§
infant	71	68	Mumps	209	201
other (wound & unspecified)	10	27	Plague	2	1
Brucellosis†	108	92	Poliomyelitis, paralytic	-	-
Chancroid	35	52	Psittacosis†	10	12
Cholera	4	1	Q fever†	66	60
Cyclosporiasis†	207	66	Rabies, human	3	2
Diphtheria	-	1	Rubella	11	7
Ehrlichiosis:	-	-	Rubella, congenital syndrome	-	1
human granulocytic (HGE)†	320	304	SARS-associated coronavirus disease† **	-	8
human monocytic (HME)†	294	254	Smallpox† ¶¶	-	NA
human, other and unspecified	31	45	*Staphylococcus aureus*:	-	-
Encephalitis/Meningitis:	-	-	Vancomycin-intermediate (VISA)† ¶¶	-	NA
California serogroup viral†§	84	108	Vancomycin-resistant (VRSA)† ¶¶	1	NA
eastern equine†§	5	13	Streptococcal toxic-shock syndrome†	92	142
Powassan†§	-	-	Tetanus	19	17
St. Louis†§	8	41	Toxic-shock syndrome	115	114
western equine†§	-	-	Trichinosis	5	4
Hansen disease (leprosy)†	76	75	Tularemia†	100	79
Hantavirus pulmonary syndrome†	19	21	Yellow fever	-	-
Hemolytic uremic syndrome, postdiarrheal†	136	159			

-: No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).
¶ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update October 24, 2004.
** Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases.
†† Of 28 cases reported, 13 were indigenous, and 15 were imported from another country.
§§ Of 52 cases reported, 31 were indigenous, and 21 were imported from another country.
¶¶ Not previously notifiable.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending December 4, 2004, and November 29, 2003 (48th Week)*

Reporting area	AIDS		Chlamydia†		Coccidiodomycosis		Cryptosporidiosis		Encephalitis/Meningitis West Nile§	
	Cum. 2004¶	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	34,915	40,627	799,145	795,709	5,646	3,796	3,090	3,205	868	2,862
NEW ENGLAND	1,149	1,371	27,044	25,688	-	-	157	182	-	31
Maine	23	49	1,933	1,848	N	N	18	19	-	-
N.H.	41	36	1,615	1,449	-	-	30	23	-	2
Vt.	14	16	895	968	-	-	24	31	-	-
Mass.	435	598	12,484	10,266	-	-	54	76	-	12
R.I.	115	101	3,096	2,749	-	-	4	16	-	5
Conn.	521	571	7,021	8,408	N	N	27	17	-	12
MID. ATLANTIC	7,373	9,489	98,857	98,868	-	-	508	420	17	223
Upstate N.Y.	792	832	20,533	18,501	N	N	175	124	5	-
N.Y. City	4,086	5,198	31,059	32,092	-	-	108	120	2	57
N.J.	1,230	1,412	13,356	14,677	-	-	33	19	1	21
Pa.	1,265	2,047	33,909	33,598	N	N	192	157	9	145
E.N. CENTRAL	2,858	3,555	137,355	144,954	13	7	877	963	61	150
Ohio	561	719	32,541	39,316	N	N	215	163	11	84
Ind.	339	483	17,022	15,646	N	N	80	97	5	15
Ill.	1,279	1,600	38,784	44,181	-	-	88	96	28	30
Mich.	537	584	33,461	29,508	13	7	142	136	12	14
Wis.	142	169	15,547	16,303	-	-	352	471	5	7
W.N. CENTRAL	727	759	49,608	45,956	6	3	391	557	85	696
Minn.	193	160	9,108	9,779	N	N	130	145	13	48
Iowa	58	83	5,900	4,693	N	N	83	119	13	81
Mo.	307	363	19,281	16,893	3	1	68	50	26	39
N. Dak.	15	3	1,373	1,466	N	N	12	12	2	94
S. Dak.	8	10	2,371	2,319	-	-	40	41	6	151
Nebr.**	41	49	4,797	4,353	3	2	28	24	7	194
Kans.	105	91	6,778	6,453	N	N	30	166	18	89
S. ATLANTIC	11,003	11,299	154,206	149,793	-	5	484	363	57	191
Del.	137	199	2,658	2,764	N	N	-	4	-	12
Md.	1,292	1,437	17,721	15,371	-	5	21	25	8	49
D.C.	785	862	3,153	2,915	-	-	13	13	1	3
Va.	567	848	19,039	17,820	-	-	59	43	4	19
W. Va.	73	84	2,574	2,393	N	N	6	4	-	1
N.C.	1,031	990	26,464	24,199	N	N	75	47	3	16
S.C.**	641	742	18,032	13,247	-	-	15	8	-	3
Ga.	1,407	1,825	27,059	32,871	-	-	173	111	12	27
Fla.	5,070	4,312	37,506	38,213	N	N	122	108	29	61
E.S. CENTRAL	1,654	1,870	51,579	50,640	4	1	115	127	60	91
Ky.	215	198	5,900	7,381	N	N	43	24	1	11
Tenn.**	684	795	20,214	18,652	N	N	29	39	13	21
Ala.	388	442	9,882	13,314	-	-	20	54	15	25
Miss.	367	435	15,583	11,293	4	1	23	10	31	34
W.S. CENTRAL	4,027	4,518	96,602	98,065	2	-	71	111	202	607
Ark.	182	171	6,519	7,239	1	-	16	18	12	23
La.	812	607	20,399	18,648	1	-	5	4	81	98
Okla.	173	202	9,275	10,337	N	N	20	18	11	56
Tex.**	2,860	3,538	60,409	61,841	N	N	30	71	98	430
MOUNTAIN	1,294	1,370	45,586	44,640	3,646	2,247	158	127	232	871
Mont.	6	13	2,092	1,930	N	N	34	18	2	75
Idaho	16	24	2,555	2,243	N	N	27	27	-	-
Wyo.	15	6	1,001	889	2	1	4	5	2	92
Colo.	288	340	11,036	11,965	N	N	54	35	39	621
N. Mex.	169	98	5,139	6,742	20	9	13	11	30	74
Ariz.	496	576	15,425	12,186	3,531	2,194	18	6	128	7
Utah	55	60	3,348	3,421	35	9	6	17	6	-
Nev.	249	253	4,990	5,264	58	34	2	8	25	2
PACIFIC	4,830	6,396	138,308	137,105	1,975	1,533	329	355	154	2
Wash.	352	420	16,190	15,235	N	N	36	58	-	-
Oreg.**	250	229	7,724	6,911	-	-	32	36	-	-
Calif.	4,061	5,632	106,642	106,502	1,975	1,533	259	260	154	2
Alaska	51	19	3,243	3,445	-	-	-	1	-	-
Hawaii	116	96	4,509	5,012	-	-	2	-	-	-
Guam	2	5	-	554	-	-	-	-	-	-
P.R.	617	940	3,183	2,411	N	N	N	N	-	-
V.I.	17	33	272	383	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	32	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.

* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

† Chlamydia refers to genital infections caused by *C. trachomatis*.

§ Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).

¶ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update October 31, 2004.

** Contains data reported through National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending December 4, 2004, and November 29, 2003 (48th Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC)						Giardiasis		Gonorrhea	
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped					
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	2,289	2,445	256	229	171	143	16,766	17,708	283,703	304,289
NEW ENGLAND	152	145	41	43	16	13	1,562	1,520	6,238	6,705
Maine	10	10	-	3	-	-	116	173	205	204
N.H.	21	18	5	3	-	-	45	38	121	115
Vt.	12	17	-	-	-	-	157	114	79	82
Mass.	65	64	10	9	16	13	681	788	2,919	2,684
R.I.	11	1	1	-	-	-	117	106	771	874
Conn.	33	35	25	28	-	-	446	301	2,143	2,746
MID. ATLANTIC	277	235	58	23	29	33	3,523	3,524	32,053	37,880
Upstate N.Y.	120	87	43	12	14	17	1,287	982	6,643	7,241
N.Y. City	35	7	-	-	-	-	884	1,125	10,001	12,529
N.J.	50	31	4	2	5	-	395	472	5,444	7,357
Pa.	72	110	11	9	10	16	957	945	9,965	10,753
E.N. CENTRAL	403	549	39	31	27	19	2,375	3,035	58,446	64,777
Ohio	95	127	9	16	20	19	750	848	16,886	20,840
Ind.	51	82	-	-	-	-	-	-	6,277	6,128
Ill.	66	120	2	2	1	-	496	872	17,202	19,897
Mich.	79	88	11	-	6	-	655	730	14,060	12,736
Wis.	112	132	17	13	-	-	474	585	4,021	5,176
W.N. CENTRAL	477	434	40	52	18	20	2,017	1,952	15,711	16,137
Minn.	112	128	19	21	1	1	790	739	2,723	2,825
Iowa	122	102	-	-	-	-	279	256	1,042	1,151
Mo.	87	81	15	18	8	1	506	487	8,304	8,025
N. Dak.	15	13	-	4	7	8	22	43	91	92
S. Dak.	33	28	2	4	-	-	73	81	276	198
Nebr.	69	48	4	5	-	-	147	136	971	1,470
Kans.	39	34	-	-	2	10	200	210	2,304	2,376
S. ATLANTIC	161	138	38	44	63	41	2,478	2,534	69,754	74,657
Del.	2	11	N	N	N	N	39	47	803	1,045
Md.	20	14	5	3	4	1	122	111	7,477	7,289
D.C.	1	1	-	-	-	-	62	49	2,355	2,318
Va.	36	37	17	13	-	-	495	332	7,546	8,260
W. Va.	2	5	-	-	-	-	40	40	833	782
N.C.	-	-	-	-	47	33	N	N	13,783	13,956
S.C.	7	2	-	-	-	-	52	130	8,790	7,771
Ga.	23	26	9	7	-	-	663	793	11,918	16,237
Fla.	70	42	7	21	12	7	1,005	1,032	16,249	16,999
E.S. CENTRAL	91	80	3	2	9	6	336	366	22,256	25,494
Ky.	28	26	1	2	6	6	N	N	2,568	3,298
Tenn.	31	34	2	-	3	-	157	169	7,641	7,781
Ala.	23	16	-	-	-	-	179	197	6,060	8,570
Miss.	9	4	-	-	-	-	-	-	5,987	5,845
W.S. CENTRAL	72	91	3	4	9	4	307	280	37,762	40,602
Ark.	14	12	1	-	-	-	118	142	3,272	3,860
La.	4	3	-	-	-	-	47	13	9,771	10,697
Okla.	19	28	-	-	4	-	142	125	3,948	4,258
Tex.	35	48	2	4	5	4	N	N	20,771	21,787
MOUNTAIN	238	307	33	26	-	7	1,425	1,503	9,908	9,590
Mont.	16	16	-	-	-	-	78	106	66	104
Idaho	50	80	16	15	-	-	181	190	88	66
Wyo.	9	4	6	1	-	-	24	21	58	40
Colo.	50	65	2	4	-	7	480	428	2,432	2,625
N. Mex.	9	13	5	5	-	-	64	51	736	1,075
Ariz.	27	38	N	N	N	N	166	232	3,710	3,365
Utah	50	68	3	-	-	-	318	342	518	361
Nev.	27	23	1	1	-	-	114	133	2,300	1,954
PACIFIC	418	466	1	4	-	-	2,743	2,994	31,575	28,447
Wash.	141	111	-	1	-	-	367	345	2,524	2,521
Oreg.	67	100	1	3	-	-	413	389	1,150	921
Calif.	199	242	-	-	-	-	1,805	2,091	26,358	23,345
Alaska	1	5	-	-	-	-	86	85	468	516
Hawaii	10	8	-	-	-	-	72	84	1,075	1,144
Guam	N	N	-	-	-	-	-	2	-	63
P.R.	1	3	-	-	-	-	125	319	229	251
V.I.	-	-	-	-	-	-	-	-	80	85
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	3	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending December 4, 2004, and November 29, 2003 (48th Week)*

Reporting area	*Haemophilus influenzae*, invasive								Hepatitis (viral, acute), by type	
	All ages		Age <5 years							
	All serotypes		Serotype b		Non-serotype b		Unknown serotype		A	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	1,654	1,693	14	25	99	100	154	188	5,209	6,950
NEW ENGLAND	146	135	1	2	6	5	4	4	932	306
Maine	12	4	-	-	-	-	-	1	11	16
N.H.	19	12	-	1	2	-	1	-	26	17
Vt.	8	9	-	-	-	-	1	-	8	6
Mass.	53	65	1	1	-	5	2	2	799	173
R.I.	6	9	-	-	1	-	-	1	22	15
Conn.	48	36	-	-	3	-	-	-	66	79
MID. ATLANTIC	368	352	1	3	5	3	37	46	637	1,710
Upstate N.Y.	115	124	1	3	5	3	5	9	106	126
N.Y. City	75	62	-	-	-	-	14	11	246	426
N.J.	71	66	-	-	-	-	4	11	137	198
Pa.	107	100	-	-	-	-	14	15	148	960
E.N. CENTRAL	251	279	1	3	6	5	36	50	502	636
Ohio	100	65	1	-	2	-	16	11	49	156
Ind.	48	45	-	-	4	-	1	8	93	62
Ill.	50	101	-	-	-	-	11	21	178	177
Mich.	19	23	-	3	-	5	6	1	131	196
Wis.	34	45	-	-	-	-	2	9	51	45
W.N. CENTRAL	100	106	2	2	3	7	12	12	162	168
Minn.	43	47	1	2	3	7	1	2	32	44
Iowa	1	-	1	-	-	-	-	-	51	27
Mo.	36	37	-	-	-	-	7	9	41	57
N. Dak.	4	4	-	-	-	-	-	-	1	2
S. Dak.	-	1	-	-	-	-	-	-	3	-
Nebr.	9	2	-	-	-	-	2	-	11	12
Kans.	7	15	-	-	-	-	2	1	23	26
S. ATLANTIC	378	375	1	2	22	17	26	23	937	1,604
Del.	-	-	-	-	-	-	-	-	5	8
Md.	62	91	-	1	5	8	-	1	103	170
D.C.	-	2	-	-	-	-	-	-	7	43
Va.	37	52	-	-	-	-	1	6	122	95
W. Va.	16	15	-	-	1	-	3	-	6	14
N.C.	55	36	1	-	6	3	1	2	99	104
S.C.	4	6	-	-	-	-	-	2	24	36
Ga.	98	69	-	-	-	-	18	7	302	753
Fla.	106	104	-	1	10	6	3	5	269	381
E.S. CENTRAL	65	76	1	1	2	3	9	9	141	254
Ky.	11	7	-	-	2	2	1	1	30	31
Tenn.	38	46	-	-	-	1	6	5	80	185
Ala.	13	21	1	1	-	-	2	3	8	23
Miss.	3	2	-	-	-	-	-	-	23	15
W.S. CENTRAL	71	73	1	2	8	10	2	4	520	647
Ark.	3	6	-	-	-	1	1	-	57	32
La.	12	21	-	-	-	2	1	4	53	45
Okla.	55	43	-	-	8	7	-	-	20	21
Tex.	1	3	1	2	-	-	-	-	390	549
MOUNTAIN	180	159	4	6	27	23	21	17	429	438
Mont.	-	-	-	-	-	-	-	-	7	8
Idaho	5	5	-	-	-	-	2	2	21	17
Wyo.	1	2	-	-	1	-	-	-	5	1
Colo.	44	35	-	-	-	-	5	6	49	62
N. Mex.	37	17	1	-	8	4	6	1	21	21
Ariz.	62	78	-	6	13	10	2	4	264	244
Utah	18	12	2	-	2	5	5	4	48	36
Nev.	13	10	1	-	3	4	1	-	14	49
PACIFIC	95	138	2	4	20	27	7	23	949	1,187
Wash.	3	11	2	-	-	7	1	3	58	65
Oreg.	43	36	-	-	-	-	3	3	61	58
Calif.	35	58	-	4	20	20	1	10	799	1,043
Alaska	4	20	-	-	-	-	1	7	5	9
Hawaii	10	13	-	-	-	-	1	-	26	12
Guam	-	-	-	-	-	-	-	-	-	2
P.R.	-	1	-	-	-	-	-	1	26	78
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending December 4, 2004, and November 29, 2003 (48th Week)*

Reporting area	Hepatitis (viral, acute), by type				Legionellosis		Listeriosis		Lyme disease	
	B		C							
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	6,102	6,513	766	994	1,725	1,983	608	613	16,633	18,991
NEW ENGLAND	340	331	14	8	58	113	43	47	2,548	3,691
Maine	2	1	-	-	-	2	7	7	53	157
N.H.	39	17	-	-	10	9	4	4	204	155
Vt.	5	4	8	8	6	6	2	1	48	43
Mass.	196	203	4	-	9	54	11	17	907	1,506
R.I.	6	18	-	-	18	15	2	-	220	564
Conn.	92	88	2	-	15	27	17	18	1,116	1,266
MID. ATLANTIC	1,180	707	136	123	502	574	144	123	11,166	12,560
Upstate N.Y.	85	88	17	16	106	142	45	33	3,832	4,189
N.Y. City	110	180	-	-	53	70	19	23	-	205
N.J.	706	171	-	-	94	85	25	23	3,132	2,809
Pa.	279	268	119	107	249	277	55	44	4,202	5,357
E.N. CENTRAL	493	479	103	134	444	418	90	85	800	900
Ohio	117	128	6	9	208	215	39	24	65	66
Ind.	39	34	9	8	72	29	16	9	18	21
Ill.	71	64	12	21	20	46	6	23	1	71
Mich.	234	209	76	91	129	110	24	19	29	9
Wis.	32	44	-	5	15	18	5	10	687	733
W.N. CENTRAL	300	315	51	245	57	66	21	16	616	418
Minn.	49	33	18	8	7	3	6	5	506	296
Iowa	14	13	-	1	6	9	3	-	44	49
Mo.	182	220	33	233	31	34	7	6	54	66
N. Dak.	4	2	-	-	2	1	-	-	-	-
S. Dak.	-	2	-	-	4	2	2	-	1	1
Nebr.	36	29	-	3	4	6	3	4	8	2
Kans.	15	16	-	-	3	11	-	1	3	4
S. ATLANTIC	1,745	1,868	151	139	362	499	107	125	1,298	1,158
Del.	28	11	-	-	12	27	N	N	137	202
Md.	157	125	19	9	73	129	17	26	755	674
D.C.	19	12	3	-	10	19	-	1	11	10
Va.	249	178	16	7	50	90	17	9	171	87
W. Va.	39	37	24	4	9	17	4	6	27	22
N.C.	172	150	11	11	38	37	26	17	112	105
S.C.	68	148	6	24	4	7	3	5	14	13
Ga.	553	622	15	13	36	34	14	30	13	10
Fla.	460	585	57	71	130	139	26	31	58	35
E.S. CENTRAL	391	437	87	82	86	97	21	29	46	60
Ky.	67	71	23	19	39	41	4	8	15	15
Tenn.	174	187	35	18	33	32	10	8	17	16
Ala.	64	91	5	6	11	19	5	11	3	8
Miss.	86	88	24	39	3	5	2	2	11	21
W.S. CENTRAL	557	1,056	117	150	64	74	27	49	33	91
Ark.	72	77	3	3	-	2	2	1	8	-
La.	61	110	67	98	4	1	3	4	5	6
Okla.	47	53	3	2	8	7	-	3	-	-
Tex.	377	816	44	47	52	64	22	41	20	85
MOUNTAIN	484	528	35	48	80	68	26	31	32	14
Mont.	2	16	2	2	2	4	-	2	-	-
Idaho	10	8	-	1	9	4	1	2	6	3
Wyo.	7	29	2	-	7	2	-	-	3	2
Colo.	56	75	-	13	19	12	12	9	-	-
N. Mex.	12	34	7	-	4	3	1	2	2	1
Ariz.	278	243	6	7	11	11	-	10	6	3
Utah	50	44	5	-	24	22	4	2	14	2
Nev.	69	79	13	25	4	10	8	4	1	3
PACIFIC	612	792	72	65	72	74	129	108	94	99
Wash.	50	69	21	18	10	10	11	7	13	3
Oreg.	104	109	15	14	N	N	7	5	32	15
Calif.	432	581	30	30	61	63	107	91	47	78
Alaska	15	6	-	-	1	-	-	-	2	3
Hawaii	11	27	6	3	-	1	4	5	N	N
Guam	-	9	-	5	-	1	-	-	-	-
P.R.	53	122	-	-	2	-	-	-	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending December 4, 2004, and November 29, 2003 (48th Week)*

Reporting area	Malaria		Meningococcal disease		Pertussis		Rabies, animal		Rocky Mountain spotted fever	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	1,170	1,226	1,156	1,505	15,703	9,058	5,502	6,396	1,384	870
NEW ENGLAND	68	60	64	70	1,550	1,629	634	567	20	9
Maine	6	2	9	6	16	12	47	65	-	-
N.H.	5	6	7	5	94	91	29	26	-	-
Vt.	4	2	3	3	88	63	35	35	1	-
Mass.	34	29	33	42	1,300	1,375	273	206	15	9
R.I.	4	2	2	2	40	20	38	64	2	-
Conn.	15	19	10	12	12	68	212	171	2	-
MID. ATLANTIC	314	337	146	188	2,630	1,170	889	865	94	40
Upstate N.Y.	50	54	36	48	1,755	595	495	401	5	-
N.Y. City	163	181	24	40	161	138	12	6	21	13
N.J.	57	60	34	26	237	169	-	62	33	16
Pa.	44	42	52	74	477	268	382	396	35	11
E.N. CENTRAL	98	102	163	233	4,687	1,107	155	166	24	21
Ohio	29	22	69	53	578	272	76	53	12	9
Ind.	17	4	24	40	232	66	10	27	6	1
Ill.	23	42	12	70	470	90	50	24	2	5
Mich.	19	23	44	43	259	119	15	48	4	6
Wis.	10	11	14	27	3,148	560	4	14	-	-
W.N. CENTRAL	64	49	83	117	1,976	436	462	609	124	63
Minn.	25	21	23	26	437	141	86	38	4	1
Iowa	4	6	17	25	194	146	104	99	1	2
Mo.	20	6	20	46	377	83	58	40	98	50
N. Dak.	3	1	2	1	724	7	57	54	-	-
S. Dak.	1	3	2	1	65	5	10	127	4	5
Nebr.	4	-	4	7	54	13	53	95	17	4
Kans.	7	12	15	11	125	41	94	156	-	1
S. ATLANTIC	309	296	196	253	617	640	1,824	2,500	699	514
Del.	6	2	3	8	8	9	9	59	4	1
Md.	72	67	10	26	123	83	292	333	72	105
D.C.	13	14	4	5	5	3	-	-	-	1
Va.	51	36	20	24	196	91	450	486	34	31
W. Va.	2	4	5	6	19	24	66	81	5	5
N.C.	19	21	28	35	80	118	556	752	484	262
S.C.	9	4	11	21	45	180	151	223	17	33
Ga.	50	64	15	31	19	30	298	378	63	64
Fla.	87	84	100	97	122	102	2	188	20	12
E.S. CENTRAL	28	28	59	84	256	146	132	203	172	123
Ky.	4	9	11	19	68	45	22	37	2	3
Tenn.	7	5	15	26	135	69	36	100	88	66
Ala.	12	7	16	20	38	18	63	62	47	21
Miss.	5	7	17	19	15	14	11	4	35	33
W.S. CENTRAL	91	123	109	167	752	703	1,022	1,090	218	90
Ark.	8	4	17	14	73	44	47	25	138	33
La.	5	4	35	39	11	10	-	5	5	1
Okla.	7	4	10	17	33	87	100	185	71	42
Tex.	71	111	47	97	635	562	875	875	4	14
MOUNTAIN	48	41	61	87	1,550	958	210	173	28	9
Mont.	1	-	3	5	58	5	26	20	3	1
Idaho	1	1	7	7	37	74	8	15	4	2
Wyo.	1	1	3	2	34	126	6	6	5	2
Colo.	15	22	15	22	835	348	43	38	1	2
N. Mex.	4	3	8	11	138	68	5	5	2	1
Ariz.	13	7	12	29	206	181	109	70	4	-
Utah	8	5	6	3	201	121	10	14	9	1
Nev.	5	2	7	8	41	35	3	5	-	-
PACIFIC	150	190	275	306	1,685	2,269	174	223	5	1
Wash.	18	25	30	32	724	707	-	-	-	-
Oreg.	16	10	55	55	442	428	6	6	3	-
Calif.	111	148	180	200	485	1,057	160	208	2	1
Alaska	2	1	3	7	12	66	8	9	-	-
Hawaii	3	6	7	12	22	11	-	-	-	-
Guam	-	1	-	-	-	1	-	-	-	-
P.R.	-	2	11	11	7	4	57	67	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending December 4, 2004, and November 29, 2003 (48th Week)*

Reporting area	Salmonellosis		Shigellosis		Streptococcal disease, invasive, group A		*Streptococcus pneumoniae*, invasive			
							Drug resistant, all ages		Age <5 years	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	36,750	39,919	11,028	21,466	4,117	5,202	1,884	1,816	646	665
NEW ENGLAND	1,874	1,978	267	318	163	430	61	95	62	9
Maine	85	127	5	6	8	27	2	-	3	-
N.H.	130	131	9	8	19	29	-	-	N	N
Vt.	57	68	3	7	8	19	9	6	3	5
Mass.	1,052	1,161	166	213	107	190	31	N	47	N
R.I.	128	122	19	19	21	15	19	10	9	4
Conn.	422	369	65	65	-	150	-	79	U	U
MID. ATLANTIC	5,127	4,605	1,073	2,220	665	879	129	124	110	95
Upstate N.Y.	1,184	1,074	399	523	220	332	54	67	78	68
N.Y. City	1,112	1,255	354	394	97	137	U	U	U	U
N.J.	914	813	221	337	146	162	-	-	7	4
Pa.	1,917	1,463	99	966	202	248	75	57	25	23
E.N. CENTRAL	4,428	5,245	1,009	1,738	782	1,202	447	395	160	292
Ohio	1,150	1,257	161	281	212	277	313	253	74	90
Ind.	532	521	189	171	93	112	134	142	39	28
Ill.	1,242	1,841	304	931	162	314	-	-	8	121
Mich.	760	737	198	229	266	340	N	N	N	N
Wis.	744	889	157	126	49	159	N	N	39	53
W.N. CENTRAL	2,266	2,318	415	741	283	316	19	18	99	70
Minn.	596	526	63	96	138	153	-	-	65	49
Iowa	408	365	63	81	N	N	N	N	N	N
Mo.	575	842	162	342	58	72	14	14	14	3
N. Dak.	41	36	3	9	12	16	-	3	4	7
S. Dak.	122	116	13	16	20	22	5	1	-	-
Nebr.	175	159	37	86	14	25	-	-	7	5
Kans.	349	274	74	111	41	28	N	N	9	6
S. ATLANTIC	10,208	10,186	2,443	6,294	789	847	904	970	54	18
Del.	81	96	6	161	3	6	4	1	N	N
Md.	771	791	141	546	165	208	-	25	40	-
D.C.	60	47	37	73	10	9	6	-	3	7
Va.	1,128	997	156	407	68	94	N	N	N	N
W. Va.	219	119	9	-	23	33	99	67	11	11
N.C.	1,565	1,263	341	927	118	100	N	N	U	U
S.C.	774	760	278	477	37	38	71	132	N	N
Ga.	1,753	1,919	593	1,112	157	167	207	218	N	N
Fla.	3,857	4,194	882	2,591	208	192	517	527	N	N
E.S. CENTRAL	2,361	2,748	738	957	189	187	123	130	5	-
Ky.	327	369	73	124	57	44	29	17	N	N
Tenn.	523	706	327	346	132	143	93	113	N	N
Ala.	684	715	291	318	-	-	-	-	N	N
Miss.	827	958	47	169	-	-	1	-	5	-
W.S. CENTRAL	3,184	5,730	2,503	5,517	236	261	62	72	115	116
Ark.	542	764	74	100	16	6	10	20	8	7
La.	753	825	261	433	2	2	52	52	26	25
Okla.	377	441	442	797	60	82	N	N	43	55
Tex.	1,512	3,700	1,726	4,187	158	171	N	N	38	29
MOUNTAIN	2,253	2,099	788	1,179	490	488	38	8	39	65
Mont.	181	108	4	2	-	1	-	-	-	-
Idaho	145	169	13	32	9	19	N	N	N	N
Wyo.	49	73	5	8	10	2	11	7	-	-
Colo.	505	461	146	309	126	127	-	-	36	49
N. Mex.	255	274	118	248	81	111	5	-	-	11
Ariz.	716	642	396	471	218	193	N	N	N	N
Utah	234	205	48	47	42	33	20	1	3	5
Nev.	168	167	58	62	4	2	2	-	-	-
PACIFIC	5,049	5,010	1,792	2,502	520	592	101	4	2	-
Wash.	546	540	105	160	53	74	-	-	N	N
Oreg.	384	409	75	207	N	N	N	N	N	N
Calif.	3,724	3,758	1,562	2,080	344	388	N	N	N	N
Alaska	56	93	6	11	-	-	-	-	N	N
Hawaii	339	210	44	44	123	130	101	4	2	-
Guam	-	43	-	34	-	-	-	-	-	-
P.R.	290	678	8	27	N	N	N	N	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	3	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending December 4, 2004, and November 29, 2003 (48th Week)*

Reporting area	Syphilis: Primary & secondary		Syphilis: Congenital		Tuberculosis		Typhoid fever		Varicella (Chickenpox)	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	6,795	6,462	296	403	10,210	11,362	258	332	16,279	15,744
NEW ENGLAND	166	195	5	1	341	379	21	27	649	3,034
Maine	2	8	-	-	-	19	-	-	222	774
N.H.	4	17	3	-	16	13	-	3	-	-
Vt.	-	1	-	-	-	9	-	-	427	721
Mass.	107	123	-	-	221	201	14	15	-	147
R.I.	22	21	1	-	30	43	1	2	-	5
Conn.	31	25	1	1	74	94	6	7	-	1,387
MID. ATLANTIC	890	811	39	60	1,863	2,038	58	75	83	38
Upstate N.Y.	89	40	4	9	256	268	8	12	-	-
N.Y. City	552	466	15	31	901	1,044	20	35	-	-
N.J.	136	163	19	20	404	409	15	21	-	-
Pa.	113	142	1	-	302	317	15	7	83	38
E.N. CENTRAL	805	824	55	72	1,082	1,075	17	32	5,521	5,538
Ohio	214	184	1	3	181	182	5	2	1,271	1,133
Ind.	53	44	9	15	122	124	-	4	61	-
Ill.	341	350	14	20	482	515	-	16	2	-
Mich.	168	230	31	33	216	193	10	10	3,795	3,497
Wis.	29	16	-	1	81	61	2	-	392	908
W.N. CENTRAL	134	139	5	5	409	428	9	6	130	75
Minn.	16	42	1	-	164	177	5	2	-	-
Iowa	5	8	-	-	33	30	-	2	N	N
Mo.	84	56	2	4	109	104	2	1	5	-
N. Dak.	-	2	-	-	4	4	-	-	82	75
S. Dak.	-	2	-	-	8	16	-	-	43	-
Nebr.	6	6	-	1	36	24	2	1	-	-
Kans.	23	23	2	-	55	73	-	-	-	-
S. ATLANTIC	1,776	1,695	50	80	2,121	2,300	43	52	1,989	2,027
Del.	8	6	1	-	-	23	-	-	4	29
Md.	325	283	9	12	226	224	11	9	-	1
D.C.	85	46	1	-	71	-	-	-	23	28
Va.	92	74	3	1	229	235	9	14	487	483
W. Va.	2	2	-	-	20	20	-	-	1,221	1,239
N.C.	174	142	11	19	291	285	8	9	N	N
S.C.	110	92	7	14	163	150	-	-	254	247
Ga.	326	459	2	13	353	478	5	6	-	-
Fla.	654	591	16	21	768	885	10	14	-	-
E.S. CENTRAL	359	296	19	12	489	638	7	7	-	-
Ky.	46	32	1	1	108	112	3	1	-	-
Tenn.	119	124	8	2	195	215	4	3	-	-
Ala.	147	106	8	7	153	210	-	3	-	-
Miss.	47	34	2	2	33	101	-	-	-	-
W.S. CENTRAL	1,103	863	50	73	1,027	1,670	19	30	5,537	4,398
Ark.	38	45	-	2	104	87	-	-	-	-
La.	261	160	-	1	-	-	-	-	50	16
Okla.	24	60	2	1	138	137	1	1	-	-
Tex.	780	598	48	69	785	1,446	18	29	5,487	4,382
MOUNTAIN	313	301	42	33	474	416	7	6	2,370	634
Mont.	-	-	-	-	14	5	-	-	-	-
Idaho	22	11	2	2	4	8	-	1	-	-
Wyo.	3	-	-	-	4	4	-	-	55	81
Colo.	38	34	-	3	95	100	2	3	1,790	-
N. Mex.	54	63	1	10	33	43	-	-	99	4
Ariz.	153	171	39	18	208	199	2	2	-	-
Utah	8	11	-	-	36	35	1	-	426	549
Nev.	35	11	-	-	80	22	2	-	-	-
PACIFIC	1,249	1,338	31	67	2,404	2,418	77	97	-	-
Wash.	131	74	-	-	216	221	6	3	-	-
Oreg.	25	42	-	-	74	99	2	4	-	-
Calif.	1,085	1,212	30	65	1,979	1,943	63	89	-	-
Alaska	1	1	-	-	35	53	-	-	-	-
Hawaii	7	9	1	2	100	102	6	1	-	-
Guam	-	1	-	-	-	48	-	-	-	143
P.R.	158	191	5	14	84	100	-	-	271	568
V.I.	4	1	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	-	U	10	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE III. Deaths in 122 U.S. cities,* week ending December 4, 2004 (48th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45–64	25–44	1–24	<1	
NEW ENGLAND	570	385	123	32	18	12	47
Boston, Mass.	138	79	36	12	4	7	6
Bridgeport, Conn.	41	27	13	1	-	-	5
Cambridge, Mass.	28	22	6	-	-	-	4
Fall River, Mass.	28	22	4	1	-	1	3
Hartford, Conn.	70	44	15	7	3	1	7
Lowell, Mass.	25	19	5	1	-	-	3
Lynn, Mass.	12	9	2	1	-	-	-
New Bedford, Mass.	29	24	5	-	-	-	4
New Haven, Conn.	U	U	U	U	U	U	U
Providence, R.I.	74	50	15	2	6	1	5
Somerville, Mass.	4	4	-	-	-	-	-
Springfield, Mass.	29	24	1	1	2	1	3
Waterbury, Conn.	22	13	5	3	1	-	4
Worcester, Mass.	70	48	16	3	2	1	3
MID. ATLANTIC	2,608	1,803	561	158	47	34	122
Albany, N.Y.	48	38	7	2	1	-	2
Allentown, Pa.	24	19	4	1	-	-	-
Buffalo, N.Y.	121	86	23	9	2	1	12
Camden, N.J.	42	27	10	3	1	1	3
Elizabeth, N.J.	21	16	3	2	-	-	1
Erie, Pa.	58	52	3	3	-	-	2
Jersey City, N.J.	52	42	7	3	-	-	-
New York City, N.Y.	1,298	898	285	75	19	19	44
Newark, N.J.	65	30	18	10	5	2	2
Paterson, N.J.	U	U	U	U	U	U	U
Philadelphia, Pa.	420	251	114	33	12	9	18
Pittsburgh, Pa.§	21	13	5	2	1	-	2
Reading, Pa.	18	14	4	-	-	-	-
Rochester, N.Y.	164	124	28	10	1	1	13
Schenectady, N.Y.	18	13	4	1	-	-	-
Scranton, Pa.	39	32	6	1	-	-	2
Syracuse, N.Y.	136	106	23	2	4	1	18
Trenton, N.J.	28	15	10	-	1	-	-
Utica, N.Y.	12	11	1	-	-	-	1
Yonkers, N.Y.	23	16	6	1	-	-	2
E.N. CENTRAL	2,287	1,549	510	125	42	60	143
Akron, Ohio	61	42	12	5	2	-	5
Canton, Ohio	39	28	9	2	-	-	4
Chicago, Ill.	355	239	79	20	10	6	34
Cincinnati, Ohio	91	57	19	6	3	6	2
Cleveland, Ohio	247	184	44	12	1	6	11
Columbus, Ohio	209	136	53	10	5	5	14
Dayton, Ohio	158	117	35	2	3	1	11
Detroit, Mich.	238	138	67	20	1	12	16
Evansville, Ind.	68	47	15	4	-	2	2
Fort Wayne, Ind.	71	53	14	1	2	1	7
Gary, Ind.	13	6	2	3	1	1	-
Grand Rapids, Mich.	49	32	10	4	3	-	3
Indianapolis, Ind.	157	110	30	7	4	6	11
Lansing, Mich.	52	33	15	2	1	1	2
Milwaukee, Wis.	156	98	36	12	4	6	10
Peoria, Ill.	67	46	16	3	1	1	1
Rockford, Ill.	67	48	16	3	-	-	5
South Bend, Ind.	59	44	11	1	1	2	-
Toledo, Ohio	76	47	21	7	-	1	1
Youngstown, Ohio	54	44	6	1	-	3	4
W.N. CENTRAL	662	417	149	46	15	24	52
Des Moines, Iowa	U	U	U	U	U	U	U
Duluth, Minn.	34	28	6	-	-	-	3
Kansas City, Kans.	64	32	19	10	3	-	5
Kansas City, Mo.	87	53	22	6	2	4	4
Lincoln, Nebr.	33	15	4	2	1	-	4
Minneapolis, Minn.	68	36	17	9	1	5	10
Omaha, Nebr.	99	75	18	4	1	1	9
St. Louis, Mo.	68	35	18	4	5	6	3
St. Paul, Minn.	60	46	7	5	1	1	3
Wichita, Kans.	149	97	38	6	1	7	11
S. ATLANTIC	1,470	932	340	115	47	36	72
Atlanta, Ga.	144	84	31	14	5	10	3
Baltimore, Md.	138	75	38	17	3	5	15
Charlotte, N.C.	120	85	27	6	-	2	9
Jacksonville, Fla.	192	128	46	8	8	2	9
Miami, Fla.	150	99	30	13	6	2	4
Norfolk, Va.	76	46	20	6	3	1	4
Richmond, Va.	69	36	23	4	4	2	4
Savannah, Ga.	54	33	13	4	3	1	2
St. Petersburg, Fla.	81	55	14	9	-	3	4
Tampa, Fla.	223	156	41	16	7	3	14
Washington, D.C.	202	119	53	17	8	5	3
Wilmington, Del.	21	16	4	1	-	-	1
E.S. CENTRAL	957	627	221	60	29	19	57
Birmingham, Ala.	139	86	33	15	3	2	15
Chattanooga, Tenn.	89	69	18	1	1	-	6
Knoxville, Tenn.	156	107	32	7	7	2	5
Lexington, Ky.	64	37	19	2	3	3	2
Memphis, Tenn.	180	109	43	11	10	7	9
Mobile, Ala.	100	80	15	4	1	-	3
Montgomery, Ala.	30	22	5	2	-	1	3
Nashville, Tenn.	199	117	56	18	4	4	14
W.S. CENTRAL	1,452	906	365	118	33	30	81
Austin, Tex.	117	76	31	7	2	1	11
Baton Rouge, La.	27	21	5	1	-	-	-
Corpus Christi, Tex.	U	U	U	U	U	U	U
Dallas, Tex.	208	108	55	30	9	6	12
El Paso, Tex.	80	65	7	6	-	2	4
Ft. Worth, Tex.	126	77	35	7	1	6	4
Houston, Tex.	346	212	89	28	11	6	14
Little Rock, Ark.	82	43	26	8	1	4	8
New Orleans, La.	55	34	16	3	2	-	-
San Antonio, Tex.	206	133	53	12	4	4	10
Shreveport, La.	76	54	15	6	1	-	5
Tulsa, Okla.	129	83	33	10	2	1	13
MOUNTAIN	958	643	215	63	19	17	51
Albuquerque, N.M.	146	100	33	10	3	-	8
Boise, Idaho	52	33	14	3	1	1	-
Colo. Springs, Colo.	62	39	12	8	1	2	1
Denver, Colo.	91	57	28	3	2	1	5
Las Vegas, Nev.	238	149	65	16	4	3	17
Ogden, Utah	33	24	5	1	-	3	5
Phoenix, Ariz.	31	20	8	2	-	1	3
Pueblo, Colo.	32	21	9	1	-	1	1
Salt Lake City, Utah	114	84	13	7	6	4	6
Tucson, Ariz.	159	116	28	12	2	1	5
PACIFIC	1,528	1,071	283	106	34	34	106
Berkeley, Calif.	25	18	5	1	-	1	1
Fresno, Calif.	50	37	6	5	1	1	1
Glendale, Calif.	16	16	-	-	-	-	1
Honolulu, Hawaii	91	71	10	5	1	4	8
Long Beach, Calif.	59	38	14	6	1	-	6
Los Angeles, Calif.	326	214	67	26	12	7	35
Pasadena, Calif.	23	18	2	2	-	1	4
Portland, Oreg.	131	94	24	9	1	3	7
Sacramento, Calif.	161	113	29	11	4	4	13
San Diego, Calif.	189	125	41	14	3	6	9
San Francisco, Calif.	138	94	28	13	3	-	6
San Jose, Calif.	U	U	U	U	U	U	U
Santa Cruz, Calif.	U	U	U	U	U	U	U
Seattle, Wash.	159	110	32	6	6	5	10
Spokane, Wash.	54	39	11	3	-	1	3
Tacoma, Wash.	106	84	14	5	2	1	2
TOTAL	12,492¶	8,333	2,767	823	284	266	731

U: Unavailable. -:No reported cases.

* Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of ≥100,000. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

† Pneumonia and influenza.

§ Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶ Total includes unknown ages.

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